

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9067

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10138

1
FOR STATE
HEALTH DEPT.

If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

M

I

1. PLACE OF DEATH a. COUNTY Dorchester Co. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Maryland.				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Yacht Basin				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Norman Middle Eldridge Last Adams Jr.				4. DATE OF DEATH Month 8 Day 18 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 4 1953	
9. AGE (In years last birthday) 8 yrs.		IF UNDER 1 YEAR Months 8 Days 18 Hours 18 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eldridge Adams		14. MOTHER'S MAIDEN NAME Margolyn Peters		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Eldridge Adams Edlon Park Cambridge, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fell into Yacht Basin while playing on pier.		INTERVAL BETWEEN ONSET AND DEATH Instant	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) Fell into Yacht Basin while playing on pier.		20c. TIME OF INJURY Month, Day, Year 8/18/61 Hour 7 p.m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Camb. Yacht Basin Cambridge, Dor. Md.		20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John Mace Jr.		M.D. John Mace Jr. M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 8/22/61	
EXAMINER'S NAME (Type) John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/20/1961	
22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or country) (State) Cambridge, Maryland.		23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Md.		24a. RECEIVED BY REGISTRAR SEP 11 1961	
24b. REGISTRAR'S SIGNATURE Arthur S. Kinner		DATE SEP 11 1961		24c. REGISTRAR'S SIGNATURE Arthur S. Kinner		DATE SEP 11 1961	

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July 27

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09059

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dor.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 3 1/2 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		d. STREET ADDRESS 28 Poplar St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle THOMAS Last ANDREWS		4. DATE OF DEATH Month Aug. Day 28 Year 1961	
5. SEX F	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/14/87
9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Md.	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William E. Thomas		14. MOTHER'S MAIDEN NAME Mary Frances Todd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4-20-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome due to cerebral arteriosclerosis, with psychosis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan 3, 1958 to Aug 28, 1961 , that (I) (we) last saw the deceased alive on Aug 28, 1961 , and that death occurred at 12:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Dredge		22b. DATE SIGNED 8-28-61	
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge		22d. ADDRESS E.S.S Hospital, Cambridge, Md.	
23a. BURIAL OR CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF August 30	23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park	23d. LOCATION (City, town, or county) (State) Cambridge, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas Jr. Cambridge		25a. REC'D BY REGISTRAR DATE AUG 31 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Kneal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2003

M



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9069

CERTIFICATE OF DEATH

Item 14 Film G293 8/17/61 mh

09060

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital				e. STREET ADDRESS 115 Maryland Ave.			
f. NAME OF DECEASED (Type or print) Lois Grace Ball				g. DATE OF DEATH August 12 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH September 23, 1913	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Hollands Island		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harrison				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-28-3961		17. INFORMANT Herbert L. Ball Sr. 115 Maryland Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Infarction - Anterior Fibular</p> <p>415X DUE TO Endocarditis</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Rheumatic CVD</p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH 30 hrs</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Thoracoplasty Left & Right Lung Lower Lobe							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-14 , 19 61 , to 8-12 , 19 61 , that (I) (we) last saw the deceased alive on 8-11 , 19 61 , and that death occurred at 5 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE W. N. Baumann, M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-12-61	
22c. PHYSICIAN'S NAME (Type) W. N. Baumann, M.D.				22d. ADDRESS 3 Church St. Cambridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem. Park		23d. LOCATION (City, town or county) (State) Cambridge, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thorne				25a. REGISTRAR'S SIGNATURE Aug 15 61		25b. REGISTRAR'S SIGNATURE James S. Prince	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

(M)

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Deceased

George W.

John

George W.

George W. (deceased)

George W. (deceased)

John

John

John

George W. (deceased)

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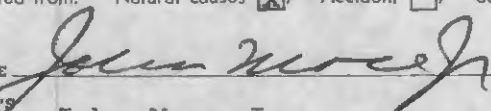

George W. (deceased)

George W. (deceased)

George W. (deceased)

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09061

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN b. Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 219 Muir St		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 219 Muir St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James First Middle Last A. Banks		4. DATE OF DEATH Month Day Year August 15 1961	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		12. KIND OF BUSINESS OR INDUSTRY Oyster House	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Sandy Cornish		16. MOTHER'S MAIDEN NAME Sarah Banks	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		18. SOCIAL SECURITY NO. 217-10-8491	
19. INFORMANT Address Rosalie Cooper Cambridge, Md.			
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion (b) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		23. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
24. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	25. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	26. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	27. (City or town) (County) (State)
28. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
29. ACTUAL SIGNATURE  EXAMINER'S NAME (Type) John Mace Jr.		30. CHIEF MEDICAL EXAMINER <input type="checkbox"/> 31. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> 32. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/16/61 DATE SIGNED Address (Street, city, town, or county) Cambridge, Md.	
33. BURIAL, CREMATION, REMOVAL (Specify) Burial	34. DATE THEREOF 8/20/61	35. NAME OF CEMETERY OR CREMATORY Old Field Cemetery	36. LOCATION (City, town, or country) (State) Cambridge, Dor. Md.
37. FUNERAL DIRECTOR Herbert St. Clair		38. ADDRESS Cambridge, Md.	
39. REC'D BY REGISTRAR AUG 22 61		40. REGISTRAR'S SIGNATURE 	

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RECEIVED
JAN 20 1950
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

9071

CERTIFICATE OF DEATH

Reg. Dist. No.

09062

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. LENGTH OF STAY IN 1b 12 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Md. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Collins Last Banks				4. DATE OF DEATH Month Aug. Day 8 Year 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 6, 1904	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months 5 Days 7		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Fertilizer MFG		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME James Mc. Daniel				14. MOTHER'S MAIDEN NAME Nannie Banks			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 220-01-0618		17. INFORMANT Martha Banks Address Cambridge, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) DIABETES M. HYPERTENSION							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES M. HYPERTENSION							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Aug. Day 7 Year 1961 Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Cambridge				20g. (County) Dorchester		20h. (State) Md.	
21. I certify that I attended the deceased from 7 AUG. 1961 to 8 AUG. 1961 , that I last saw the deceased alive on 7 AUG. 1961 , and that death occurred at Cambridge, Md. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. E. Guinby Jr.				ADDRESS (Street, city or town, state) 105 Church St. Cambridge, Md.			
PHYSICIAN'S NAME (Type) W. E. GUINBY JR.				DATE SIGNED 11 AUG 61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/14/1961		22c. NAME OF CEMETERY OR CREMATORY Trappe Cemetery		22d. LOCATION (City, town, or county) (State) Trappe, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Herbert M. St. Clair Jr.				24a. REC'D BY REGISTRAR Aug 15 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1971

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death	
6. Place of birth		7. Usual residence		8. Cause of death		9. Manner of death		10. Signature of physician	
11. Signature of registrar		12. Signature of informant		13. Signature of medical examiner		14. Signature of coroner		15. Signature of funeral director	
16. Signature of health officer		17. Signature of registrar		18. Signature of informant		19. Signature of medical examiner		20. Signature of coroner	
21. Signature of health officer		22. Signature of registrar		23. Signature of informant		24. Signature of medical examiner		25. Signature of coroner	
26. Signature of health officer		27. Signature of registrar		28. Signature of informant		29. Signature of medical examiner		30. Signature of coroner	
31. Signature of health officer		32. Signature of registrar		33. Signature of informant		34. Signature of medical examiner		35. Signature of coroner	
36. Signature of health officer		37. Signature of registrar		38. Signature of informant		39. Signature of medical examiner		40. Signature of coroner	
41. Signature of health officer		42. Signature of registrar		43. Signature of informant		44. Signature of medical examiner		45. Signature of coroner	
46. Signature of health officer		47. Signature of registrar		48. Signature of informant		49. Signature of medical examiner		50. Signature of coroner	
51. Signature of health officer		52. Signature of registrar		53. Signature of informant		54. Signature of medical examiner		55. Signature of coroner	
56. Signature of health officer		57. Signature of registrar		58. Signature of informant		59. Signature of medical examiner		60. Signature of coroner	
61. Signature of health officer		62. Signature of registrar		63. Signature of informant		64. Signature of medical examiner		65. Signature of coroner	
66. Signature of health officer		67. Signature of registrar		68. Signature of informant		69. Signature of medical examiner		70. Signature of coroner	
71. Signature of health officer		72. Signature of registrar		73. Signature of informant		74. Signature of medical examiner		75. Signature of coroner	
76. Signature of health officer		77. Signature of registrar		78. Signature of informant		79. Signature of medical examiner		80. Signature of coroner	
81. Signature of health officer		82. Signature of registrar		83. Signature of informant		84. Signature of medical examiner		85. Signature of coroner	
86. Signature of health officer		87. Signature of registrar		88. Signature of informant		89. Signature of medical examiner		90. Signature of coroner	
91. Signature of health officer		92. Signature of registrar		93. Signature of informant		94. Signature of medical examiner		95. Signature of coroner	
96. Signature of health officer		97. Signature of registrar		98. Signature of informant		99. Signature of medical examiner		100. Signature of coroner	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9072

CERTIFICATE OF DEATH

Reg. Dist. No.

181163

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 32 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Preston Boring		4. DATE OF DEATH Aug 30 1961	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22 1874
9. AGE (In years, last birthday) 87 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sta. Engineer		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Boring		14. MOTHER'S MAIDEN NAME Matilda Fleagle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-9957	
17. INFORMANT Hospital Records Cambridge		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNK	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 28 , 1961, to Aug 30 , 1961, that I last saw the deceased alive on Aug 29 , 1961, and that death occurred at 9:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Thomas J. Dredge M.D. E.S.S. Hospital, Cambridge, Md. 8-30-61			
ACTUAL SIGNATURE Thomas J. Dredge			
PHYSICIAN'S NAME (Type) Thomas J. Dredge, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Aug 30 1961	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Greenmount Cemetery		Greenmount Md	
23. FUNERAL DIRECTOR'S SIGNATURE Hamilton Harrison & Mical		24a. REC'D BY REGISTRAR DATE SEP 5 '61	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur E. H.	

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be examined within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



9073

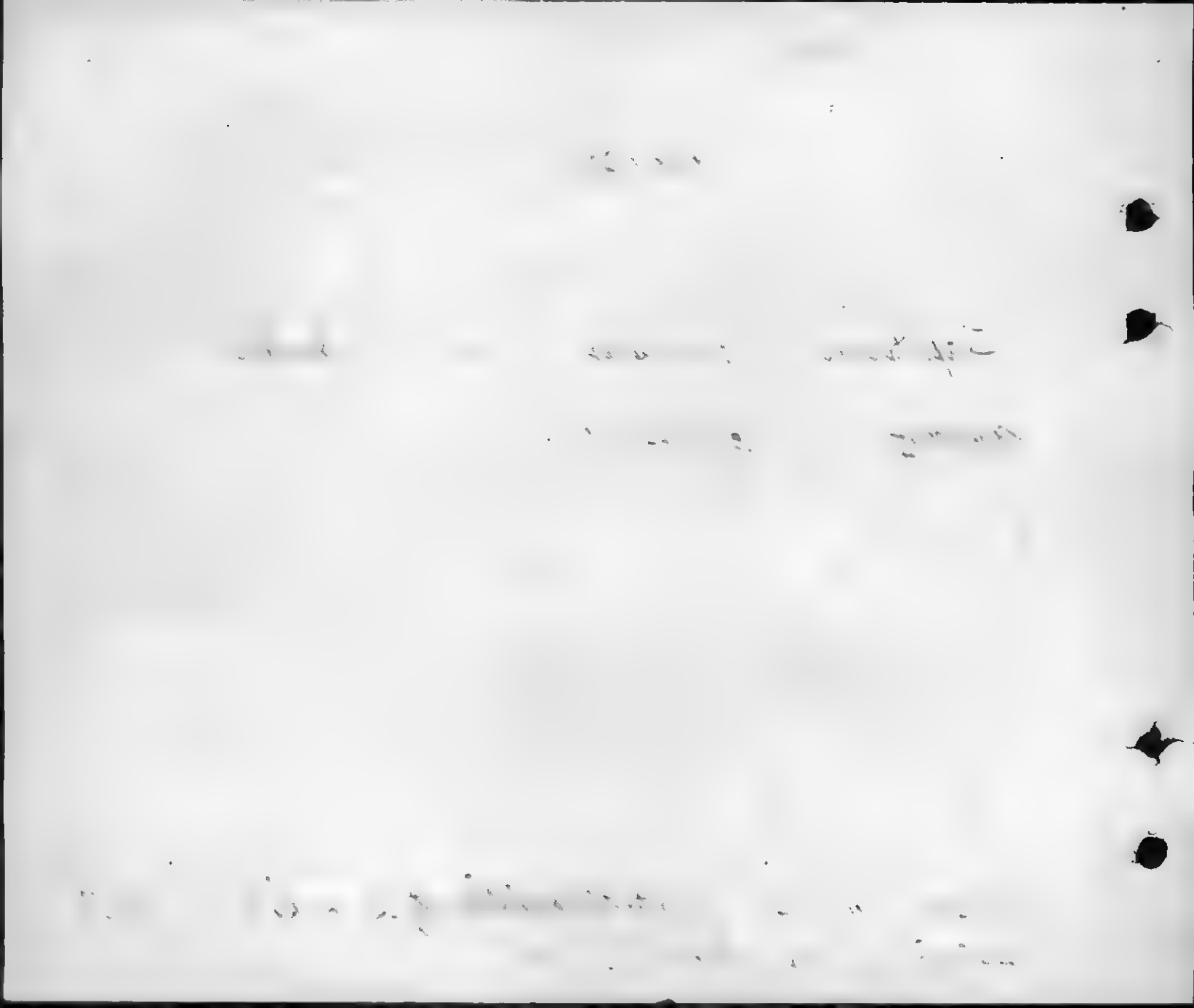
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

194:64

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Cambridge		c. LENGTH OF STAY IN 1b 17mo-11 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Shore State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Gordon Middle Henry Last Bowen		4. DATE OF DEATH Month Aug Day 10 Year 1961	
5. SEX M	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1912
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 10 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY own bal	
11. BIRTHPLACE (State or foreign country) Maryland, Snow Hill		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Isaac Bowen		14. MOTHER'S MAIDEN NAME Pearl Hales	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) World War Army		16. SOCIAL SECURITY NO. 318-24-2769	
17. INFORMANT Hospital Records Cambridge Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cancer of Pancreas DUE TO 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) UNK DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 1 1961 to Aug 10 1961 , that (I) (we) last saw the deceased alive on Aug 9 1961 , and that death occurred at 6:15 M , from the causes and on the date stated above			
22a. SIGNATURE Thomas J. Dredge		22b. DATE SIGNED 8-10-61	
22c. PHYSICIAN'S NAME (Type) Thomas J. Dredge		22d. ADDRESS E.S.S. Hospital, Cambridge, Md.	
23a. BURIAL CREMATION REMOVAL (Specify) Buried		23b. DATE THEREOF Aug 12/61	
23c. NAME OF CEMETERY OR CREMATORY Bates Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Snow Hill Md	
24. FUNERAL DIRECTOR'S SIGNATURE Wayne Dennis		25a. REC'D BY REGISTRAR Aug 14 '61	
ADDRESS Snow Hill, Md		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

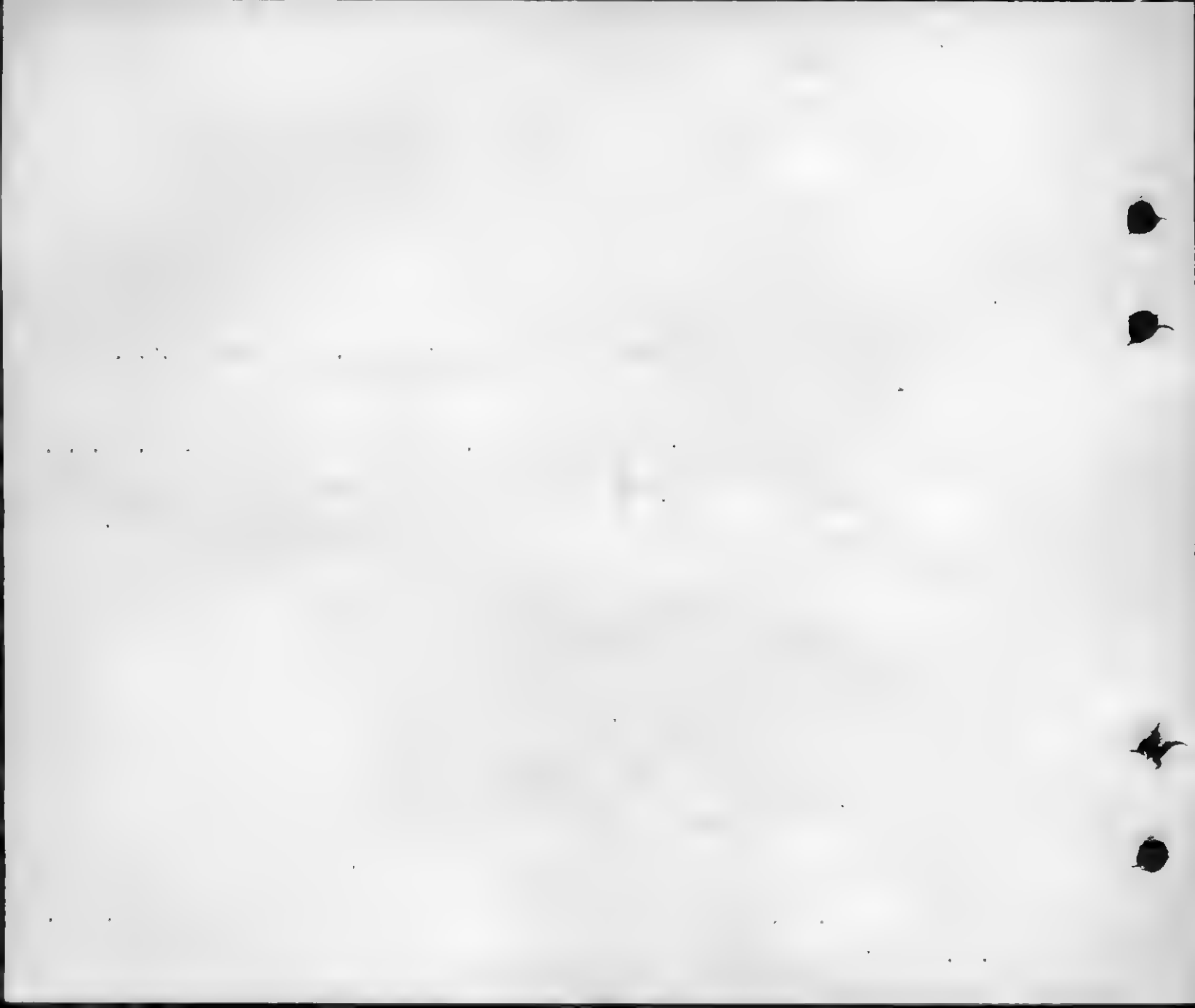
(M)

9074

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09065

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural		c. LENGTH OF STAY IN 1b Life		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rhodesdale - Rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eldorado				d. STREET ADDRESS Eldorado		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Wainwright Last Brinsfield				4. DATE OF DEATH Month August Day 12 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 10, 1900		9. AGE (In years last birthday) 60 yrs	IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min 0	IF UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Dorchester Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. George Wainwright				14. MOTHER'S MAIDEN NAME Jennie D. Brinsfield			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-10-9650		17. INFORMANT Elwood H. Brinsfield, Rhodesdale, Md., R.F.D. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO metastatic carcinoma of the Breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) Diabetes Mellitus				INTERVAL BETWEEN ONSET AND DEATH 5 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Aug Day 12 Year 1961 Hour 8:28 a. m. PM		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 12, 1961 to Aug 12, 1961 , that (I) (we) last saw the deceased alive on Aug 12, 1961 , and that death occurred at 8:28 PM from the causes and on the date stated above.							
22a. SIGNATURE R. Kingsbury				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS Seaford, Del.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 15, 1961		23c. NAME OF CEMETERY OR CREMATORY Eldorado Cemetery		23d. LOCAT ON (City, town, or county) (State) Eldorado, Dorchester Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REG STRAR DATE AUG 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hanes	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9075

09066

1. PLACE OF DEATH
a. COUNTY **Dorchester** MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cambridge**
c. LENGTH OF STAY IN 1b **25 years**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Cambridge-Maryland Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Dorchester**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Cambridge**
d. STREET ADDRESS **134 East Appleby Ave.,**

3. NAME OF DECEASED (Type or print)
First **Sina** Middle **Gertrude** Last **Burton**

4. DATE OF DEATH **August 25, 1961** 19 **19**
Month Day Year

5. SEX **Female** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH **October 23, 1889** 71 yrs.
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Homemaker** 10b. KIND OF BUSINESS OR INDUSTRY **Applegarth's, Dor. Co.,** 12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME **James E. Ruark** 14. MOTHER'S MARDEN NAME **Julia Lewis**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. **Julia Lewis** Address **R. Julian Burton, E. Appleby Ave., Cambridge, Md.**

18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **LYMPHO SARCOMA, GENERALIZED**
200.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 2b.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 **20c. INJURY OCCURRED** While at work ☐ Not While at work ☐ 20d. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) 20e. (City or town) (County) (State)

21. I certify that (I) (th's hospital) attended the deceased from **Jan 28, 1958** to **Aug 25, 1961**, that (I) (we) last saw the deceased alive on **Aug 24, 1961**, and that death occurred at **6 AM**, from the causes and on the date stated above.

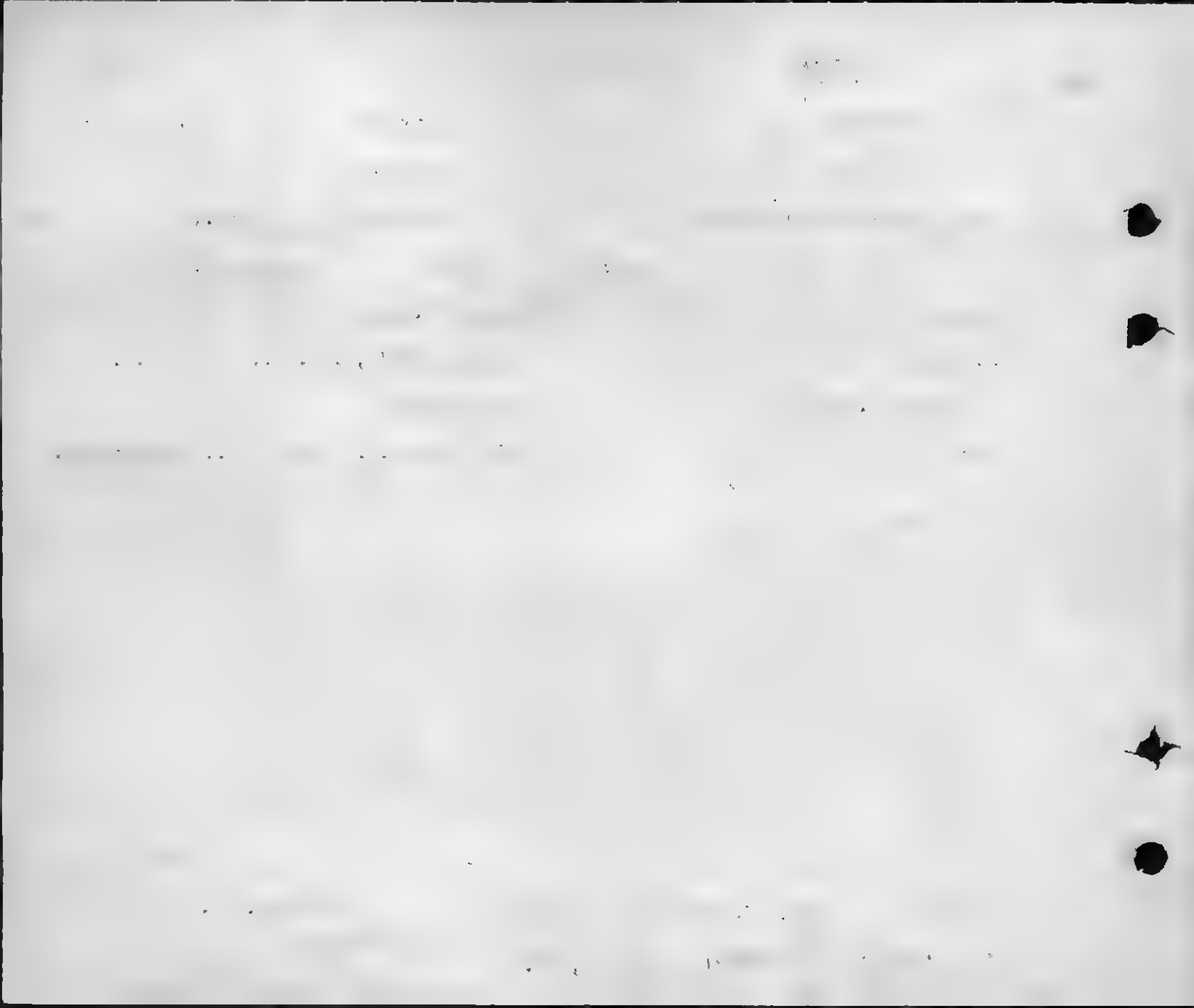
22a. SIGNATURE **Alfred R. Maryanov** M.D. 22b. DATE SIGNED **8/26/61**
22c. PHYSICIAN'S NAME (Type) **ALFRED R. MARYANOV** 22d. ADDRESS **136 RACE ST. CAMBRIDGE, MD**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **August 27, 1961** 23c. NAME OF CEMETERY OR CREMATORY **Green Lawn Cemetery** 23d. LOCATION (City, town or county) (State) **Cambridge, Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **Kenneth R. Thomas** ADDRESS **Cambridge, Md.** 25a. RECEIVED BY REGISTRAR **Aug 29 1961** 25b. REGISTRAR'S SIGNATURE **Arthur L. H. H.**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

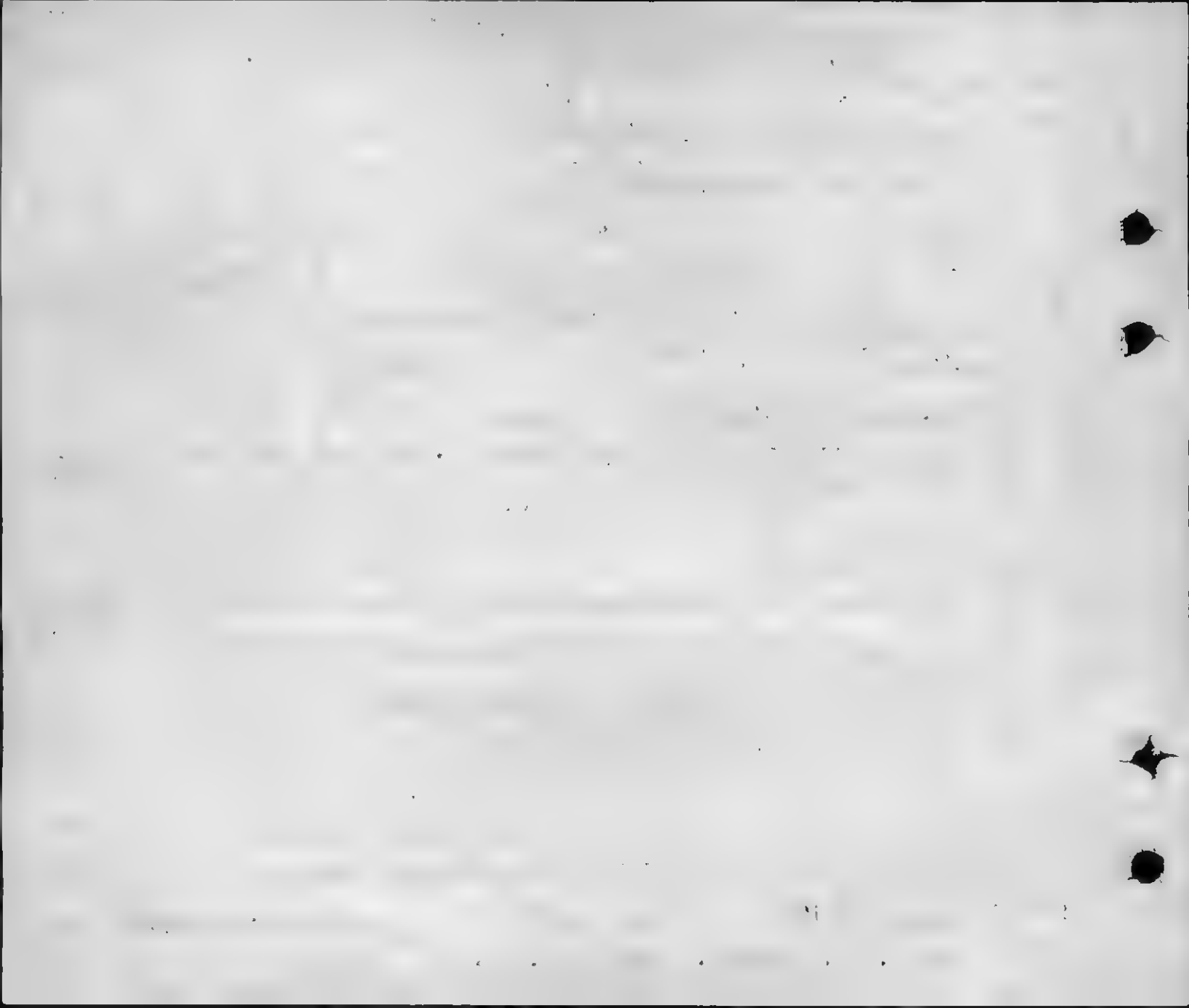
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9077 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09068

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>		c. LENGTH OF STAY in 1b <u>1 yr 4mos</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Painter</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) First <u>FLOYD</u> Middle _____ Last <u>COLLINS</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1939</u>	9. AGE (In years last birthday) <u>22</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James H. Collins</u>				14. MOTHER'S MAIDEN NAME <u>Olevia Upshur</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-50-4131</u>		17. INFORMANT <u>James H. Collins, Williamsburg, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probable drowning</u> 929.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Found floating</u>					
20c. TIME OF INJURY Month, Day, Year <u>8/7/ 19 61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Town to juice pit</u>		20f. (City or town) <u>Williamsburg, Dorchester, Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. _____		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/7/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Rem-Burial</u>		22b. DATE THEREOF <u>8/10/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Painter Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Painter, Virginia</u>	
23. FUNERAL DIRECTOR <u>Herbert M. St. Clair, Jr., Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22 & 23 Fill in 2201 9/11/61 mh

CERTIFICATE OF DEATH

Reg. Dist. No. 09069

3078

Items 24 Fill in 2201 9/13/61 ink

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			c. LENGTH OF STAY IN TB 36 MRS. 3 MRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge, Md.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge, Md. Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Fredericka Middle Ann Last Collins				4. DATE OF DEATH Month Aug. Day 29 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 28-1961		9. AGE (In years last birthday) 1 yrs. IF UNDER 1 YEAR: Months 1 Days 30 Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Collins				14. MOTHER'S MAIDEN NAME Carol A. Posette			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mother-101 Academy St. Camb., Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							INTERVAL BETWEEN ONSET AND DEATH 36 hrs.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Immaturity 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour 19 Month 19 Day 19 Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-28-1961 , to 8-29-1961 , that I last saw the deceased alive on 8-29-1961 , and that death occurred at 12:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8-30-61							
ACTUAL SIGNATURE Dr. Wilbur N. Baumann M.D.				PHYSICIAN'S NAME (Type) Dr. Wilbur N. Baumann 3 Church St. Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/30/61		22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Granville Le Compte				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR DATE SEP 5 '61	
				24b. REGISTRAR'S SIGNATURE John S. Hanks			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9079

CERTIFICATE OF DEATH

Reg. Dist. No.

09070

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge			
c. LENGTH OF STAY in 1b Life				13			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cambridge Maryland Hospital				d. STREET ADDRESS 230 Pine Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Lillian Middle Foster Last Cornish				4. DATE OF DEATH Month Aug. Day 14 Year 1961			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1916	
9. AGE (In years last birthday) 44 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Canning		11. BIRTHPLACE (State or foreign country) Dorchester Co., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Henry Foster		14. MOTHER'S MAIDEN NAME Evelyn Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-01-9789		17. INFORMANT Address Evelyn Foster, Cambridge, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from February 1, 1961 to August 14, 1961 , that I last saw the deceased alive on August 14, 1961 , and that death occurred at 10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ M.D. 227 Pine St., Cambridge, Md. 8-17-61							
ACTUAL SIGNATURE _____							
PITUITARIAN'S NAME (Type) J. Edwin Fassett, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/1961		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Fosse				24a. REC'D BY REGISTRAR DATE AUG 22 61		24b. REGISTRAR'S SIGNATURE Arthur L. Fosse	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

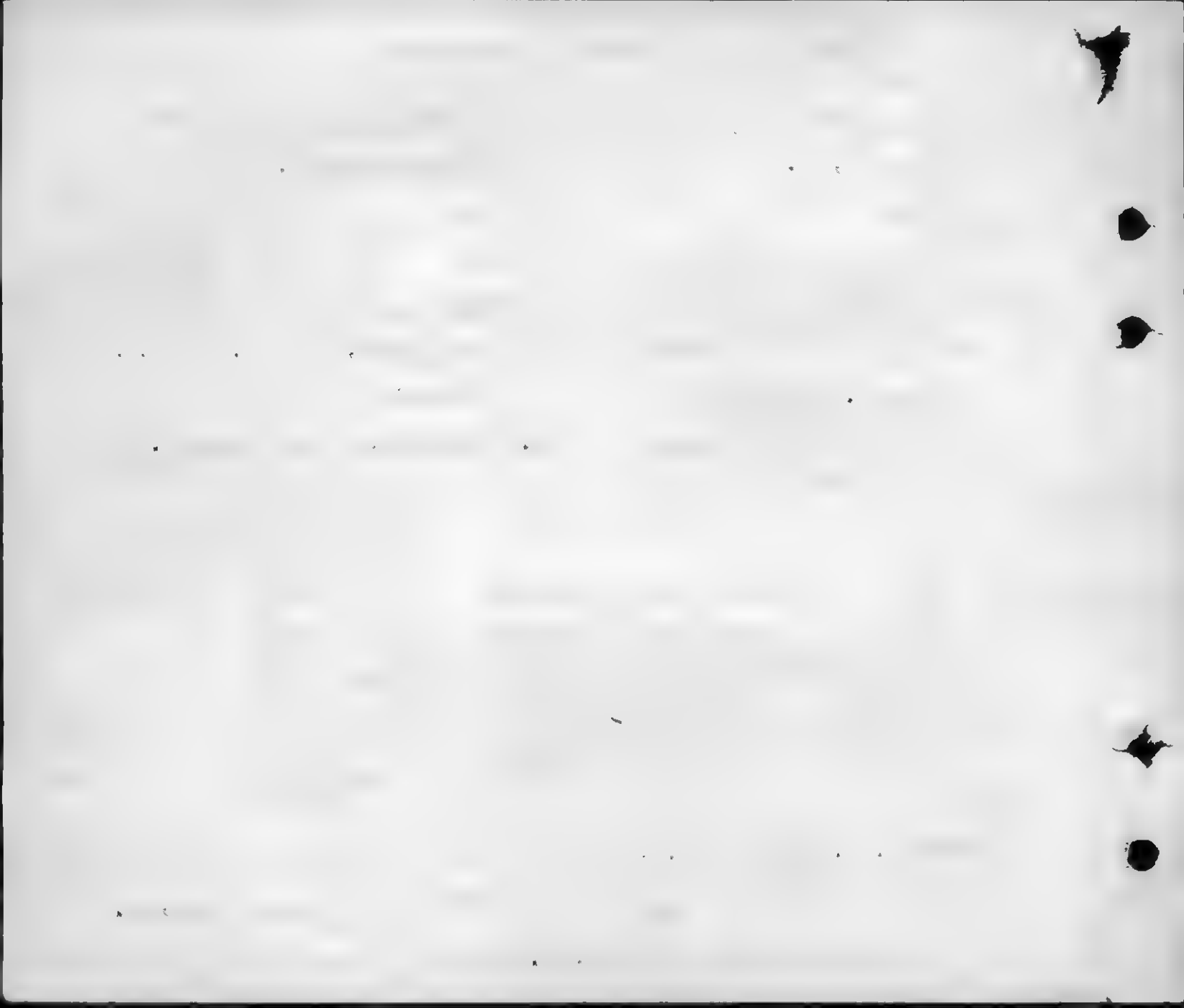
9080

CERTIFICATE OF DEATH

Reg. Dist. No. 09071

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek, Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fishing Creek, Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lucy Middle Creighton Last Creighton				4. DATE OF DEATH Month 8 Day 17 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/1879	
9. AGE (In years last birthday) 82 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood		10b. KIND OF BUSINESS OR INDUSTRY Seafood		11. BIRTHPLACE (State or foreign country) Fishing Creek, Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Robert F. Creighton			
14. MOTHER'S MAIDEN NAME Henrietta Parker				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO Unknown				17. INFORMANT Mrs. Hansel Hall, Fishing Creek, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Arteriosclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis CVD DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 15 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertension							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-23-1956 to 8-17-1961 , that I last saw the deceased alive on 8-10-1961 , and that death occurred at 7:41 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Church Street DATE SIGNED							
ACTUAL SIGNATURE [Signature] M.D.				PHYSICIAN'S NAME (Type) W. N. Baumann, M.D. Cambridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/1961		22c. NAME OF CEMETERY OR CREMATORY Hoosier Memorial Church Yard		22d. LOCATION (City, town, or county) (State) Fishing Creek, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.				24a. BY REGISTRAR 208 15 61		24b. REGISTRAR'S SIGNATURE Arthur S. Krawe	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be completed within 24 hours after death. Page 1 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on completely filled form by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

(M)

(I)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If necessary, it may be executed by the funeral director. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9081

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09072

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN 1b 60 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 306 Henry Street		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cambridge d. STREET ADDRESS 306 Henry Street	
3. NAME OF DECEASED (Type or print) Joseph Ralph Dodson		4. DATE OF DEATH Month Day Year August 16, 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH December 28, 1881	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman self employed		11. BIRTHPLACE (State or foreign country) Somerset County	
13. FATHER'S NAME James Dodson		14. MOTHER'S MAIDEN NAME Ida McClain	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 1	
17. INFORMATION Raymond J. Dodson, 306 Henry St., Cambridge, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Starvation DUE TO (b) Carcinoma stomach DUE TO (c) 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE THEREOF Aug. 18, 1961	
23. NAME OF CEMETERY OR CREMATORY Green Lawn Cemetery		24. LOCATION (City, town, or country) Cambridge, Md.	
25. FUNERAL DIRECTOR Herbert R. House		26. REGISTRAR'S SIGNATURE Arthur S. House	

MEDICAL CERTIFICATION

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

John Mace Jr.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

8/17/61

Address (Street, city, town, or county)

Cambridge, Md.

(State)

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22c. NAME OF CEMETERY OR CREMATORY

Green Lawn Cemetery

22d. LOCATION (City, town, or country)

Cambridge, Md.

23. FUNERAL DIRECTOR

ADDRESS

Cambridge, Md.

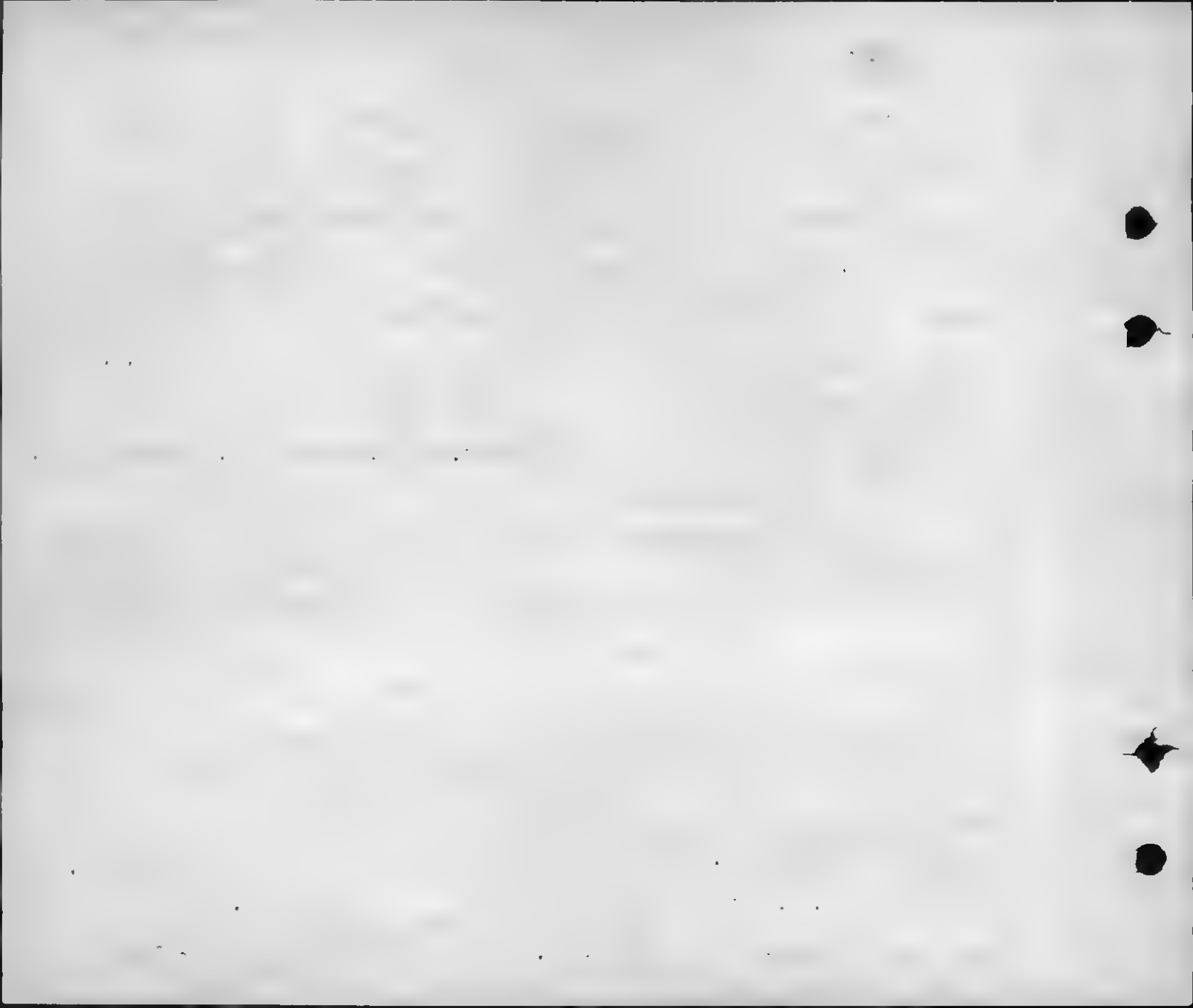
24a. REC'D BY REGISTRAR

AUG 21 '61

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. House



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
0082 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09073											
1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Dorchester					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. Cambridge Md. Hospital						d. STREET ADDRESS 23 Robbins St.					
3. NAME OF DECEASED (Type or print) Grant						4. DATE OF DEATH Aug. 9 1961					
5. SEX Male						6. COLOR OR RACE Negro					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH 3/12/1910					
9. AGE (in years last birthday) 51 yrs.						10. IF UNDER 1 YEAR Months Days					
11. IF UNDER 24 HRS. Hours Min.						12. CITIZEN OF WHAT COUNTRY? U.S.A.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer						10b. KIND OF BUSINESS OR INDUSTRY Food Canning					
11. BIRTHPLACE (State or foreign country) Maryland						12. MOTHER'S MAIDEN NAME Amelia Travers					
13. FATHER'S NAME Grant Ennalls Sr.						14. MOTHER'S MAIDEN NAME Amelia Travers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 213-12-569					
17. INFORMANT Mrs. Christina E. Ennalls; Cambridge, Md						Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Instant											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/10/61 Address (Street, city, town, or county) Cambridge, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 8/13/61					
22c. NAME OF CEMETERY OR CREMATORY Crapo Cemetery						22d. LOCATION (City, town, or country) (State) Crapo, Dor. Md.					
23. FUNERAL DIRECTOR Herbert St. Clair						24a. REC'D BY REGISTRAR Aug 22 '61					
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

SIGNATURE

EXAMINER'S NAME (Type)

Dr. John Mace Jr. M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED

8/10/61

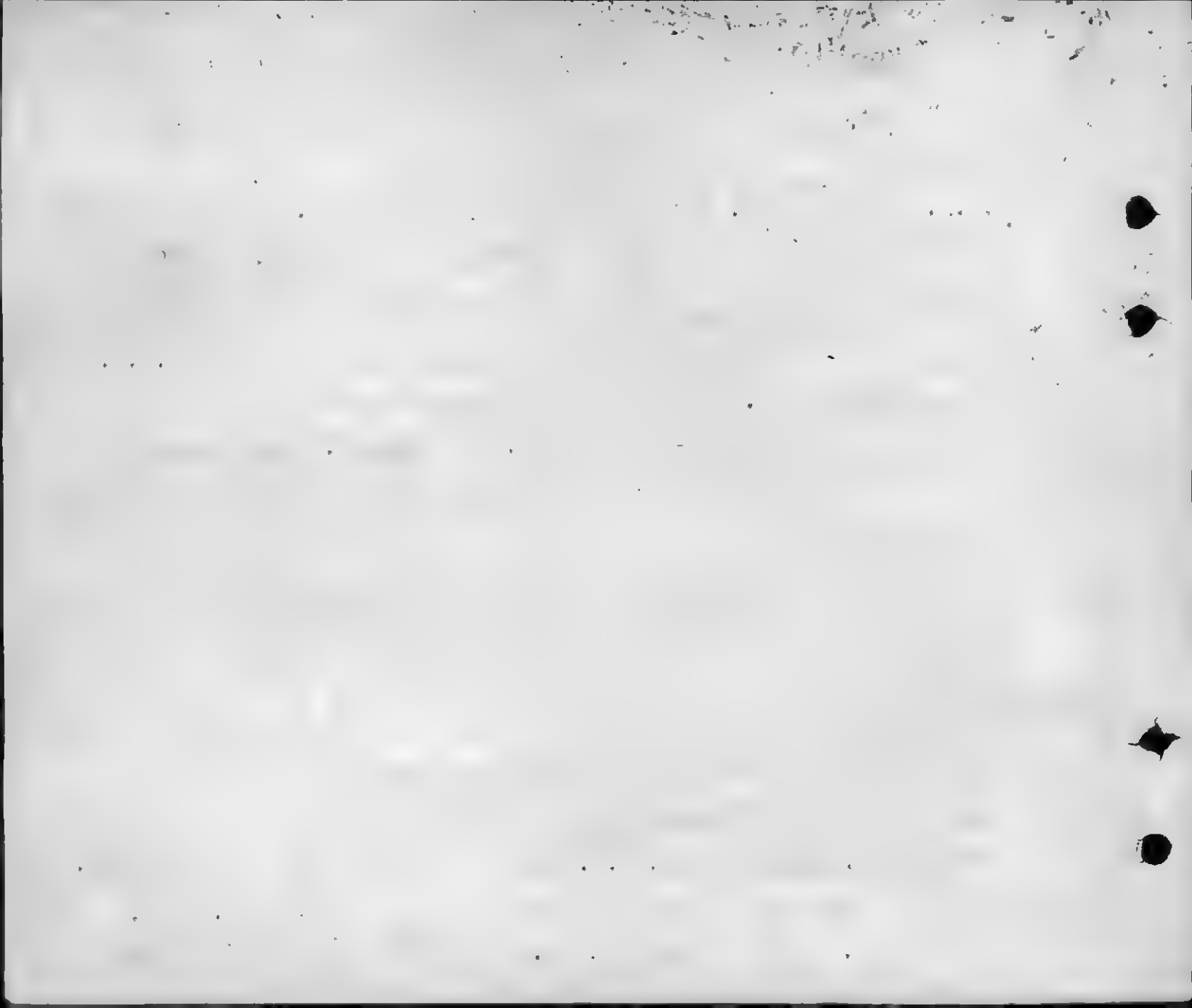
Cambridge, Md.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

9083
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10147

1. PLACE OF DEATH
a. COUNTY Dorchester
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Elliot
c. LENGTH OF STAY IN 1b all life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____

2. USUAL RESIDENCE (Where deceased lived, if Institution, residence before admission)
a. STATE MD
b. COUNTY Dor
c. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) Elliot
d. STREET ADDRESS _____

3. NAME OF DECEASED (Type or print) Swain Robert Lee Ewell
First Middle Last
4. DATE OF DEATH 8 26 19 61
Month Day Year
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 7/27/1876
9. AGE (in years, months, days) 85 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10a. US. J.A. OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman Retired
10b. KIND OF BUSINESS OR INDUSTRY _____
11. BIRTHPLACE (State or foreign country) MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Salomon Ewell
14. MOTHER'S MAIDEN NAME Mary H. Haller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) no (If yes, give year or dates of service) _____
16. SOCIAL SECURITY NO. _____
17. INFORMANT Mrs Emerson Moore Elliott Address _____
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1-20.1 DUE TO Coronary occlusion
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO _____
(c) _____
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. _____
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 _____
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____
20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☐ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county) _____
DATE SIGNED 8/27/61
ACTUAL SIGNATURE John Mace Jr M.D.
EXAMINER'S NAME (Type) JOHN MACE JR
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8/28/61
22c. NAME OF CEMETERY OR CREMATORY family
22d. LOCATION (City, town, or country) Elliot MD (State) _____
23. FUNERAL DIRECTOR Ruth S. Hillyer Address _____
24a. REC'D BY REGISTRAR _____
24b. REGISTRAR'S SIGNATURE _____



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9084 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film G295 9/18/61 iwk

Reg. Dist. No.

09074

1. PLACE OF DEATH a. COUNTY Dorchester		b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) Cambridge		c. LENGTH OF STAY IN 1b 3 days		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Caroline		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillsboro		d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie		First		Middle		Last Flaming		4. DATE OF DEATH August		Month		Day 21		Year 19 61	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-17-91		9. AGE (in years last birthday) 69 1/4 yrs		10. IF UNDER 1 YEAR Months		Days		11. IF UNDER 24 HRS. Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Hackett Holt		14. MOTHER'S MAIDEN NAME Ella DuPont Turner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT RECORDS - Eastern Shore State Hospital		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 4x5x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture neck left humerus 8/2/61		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Slipped and fell in home	
20c. TIME OF INJURY Month, Day, Year 9 AM 8/2/61 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hillsboro, Caroline, Md.		(County)		(State)		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. REC'D BY REGISTRAR DATE AUG 24 '61	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. REC'D BY REGISTRAR DATE AUG 24 '61		22b. REGISTRAR'S SIGNATURE Arthur S. Kram		22c. NAME OF CEMETERY OR CREMATORY Hillsboro Episcopal		22d. LOCATION (City, town, or county) Hillsboro		(State) Md.		22e. DATE THEREOF Aug 24, 1961		22f. REMOVAL (Specify) Burial	
23. FUNERAL DIRECTOR'S SIGNATURE J. Virginia + Son		23a. ADDRESS Denton, Md.		23b. DATE 8/21/61		23c. NAME John Mace Jr.		23d. ADDRESS Denton, Md.		23e. DATE 8/21/61		23f. NAME John Mace Jr.		23g. ADDRESS Denton, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

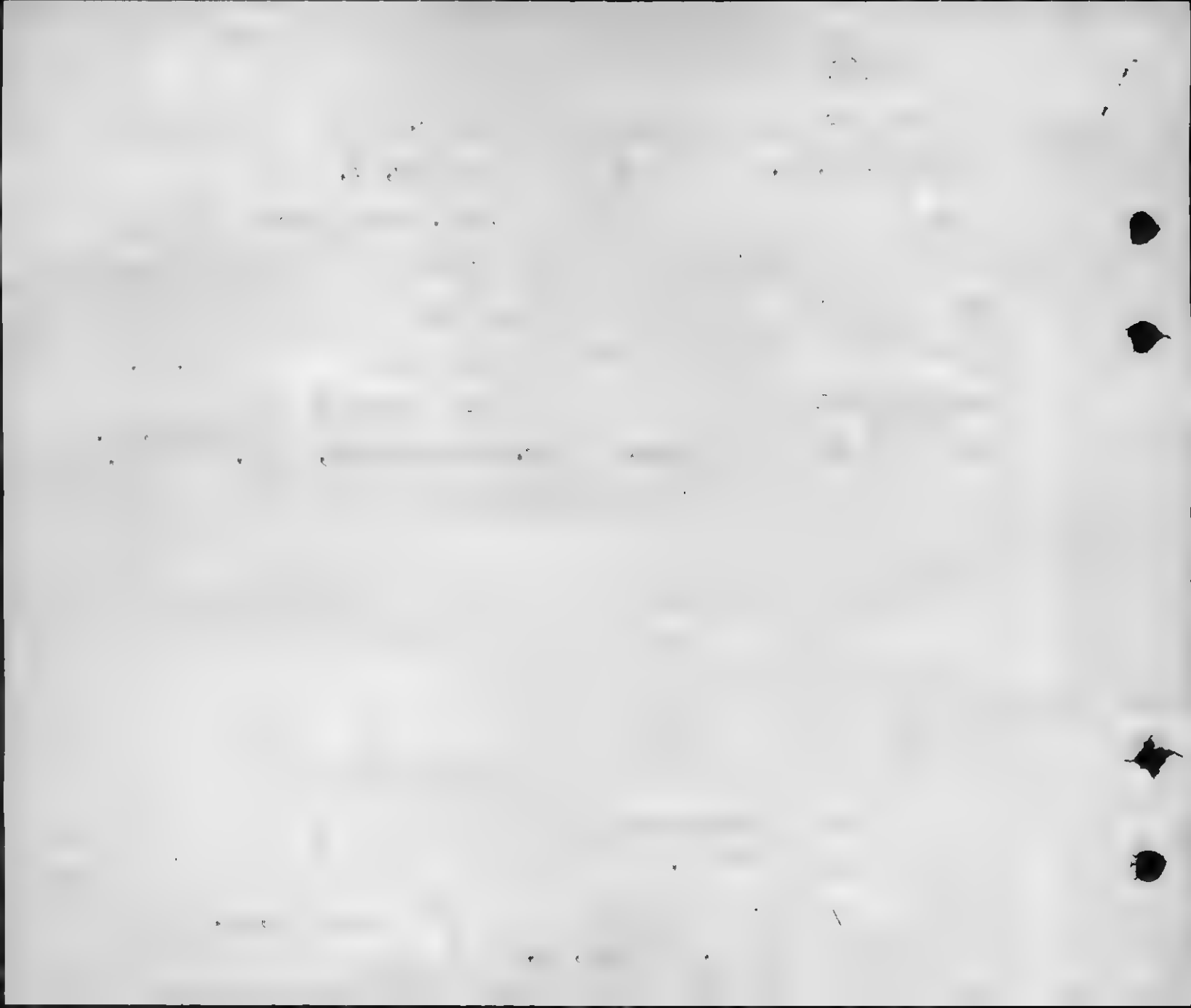
9085

09075

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and may event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Dorchester Co b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) East New Market, Md. c. LENGTH OF STAY IN b. 5 Weeks d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pa. b. COUNTY Lancaster c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lancaster, Pa. d. STREET ADDRESS 618 S. Prince Street	
3. NAME OF DECEASED (Type or print) Webster		4. DATE OF DEATH Friedel 8 15 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 2 1886	
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR 15 Months 15 Days 15 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Shop		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
11. BIRTHPLACE (State or foreign country) Felton Del		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Friedel		14. MOTHER'S MAIDEN NAME Ella Wallheater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Mrs. Webster Friedel, 618 S. Prince St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO (b) 20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John Mace Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 8/16/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/18/1961	
22c. NAME OF CEMETERY OR CREMATORY Cedar Lawn		22d. LOCATION (City, town, or country) (State) Lancaster, Pa.	
23. FUNERAL DIRECTOR Le Compte Funeral Service, Cambridge, Md.		24a. REC'D BY REGISTRAR AUG 18 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Mace	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE
HEALTH DEPT
M

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <u>Dor.</u>										2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admision) a. STATE <u>Md.</u> b. COUNTY <u>Dor.</u>																			
b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Airay</u>										c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Airay</u>																			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>all life</u>										d. STREET ADDRESS <u>Airay</u>																			
3. NAME OF DECEASED (Type or print) <u>Harbert Linwood Harper</u>										4. DATE OF DEATH <u>8-15-1961</u>																			
5. SEX <u>M</u> COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1/27/83</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.																													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>										10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>																			
13. FATHER'S NAME <u>Thomas Harper</u>										14. MOTHER'S MAIDEN NAME <u>Elizabeth Dunn</u>																			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>										16. SOCIAL SECURITY NO <u> </u>																			
17. INFORMANT <u>Harbert L. Harper Jr</u> Address <u>Airay Md</u>										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 42011 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c) <u> </u> (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> 19 <u> </u>										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>																			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>										20f. (City or town) (County) (State) <u> </u>																			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <u>John Mace Jr</u>										CHIEF MEDICAL EXAMINER <input type="checkbox"/>																			
EXAMINER'S NAME (Type) <u>JOHN MACE JR.</u>										M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>																			
										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
										Address (Street, city, town, or county) <u> </u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>										22b. DATE THEREOF <u>8/18/61</u>																			
22c. NAME OF CEMETERY OR CREMATORY <u>East New Market</u>										22d. LOCATION (City, town, or county) (State) <u>East New Market, Md</u>																			
23. FUNERAL DIRECTOR <u>Frank S. Helmsky</u>										ADDRESS <u>East New Market, Md</u>																			
24a. REC'D BY REGISTRAR <u>AUG 22 '61</u>										24b. REGISTRAR'S SIGNATURE <u> </u>																			

VS. A15ME
5M 7/59



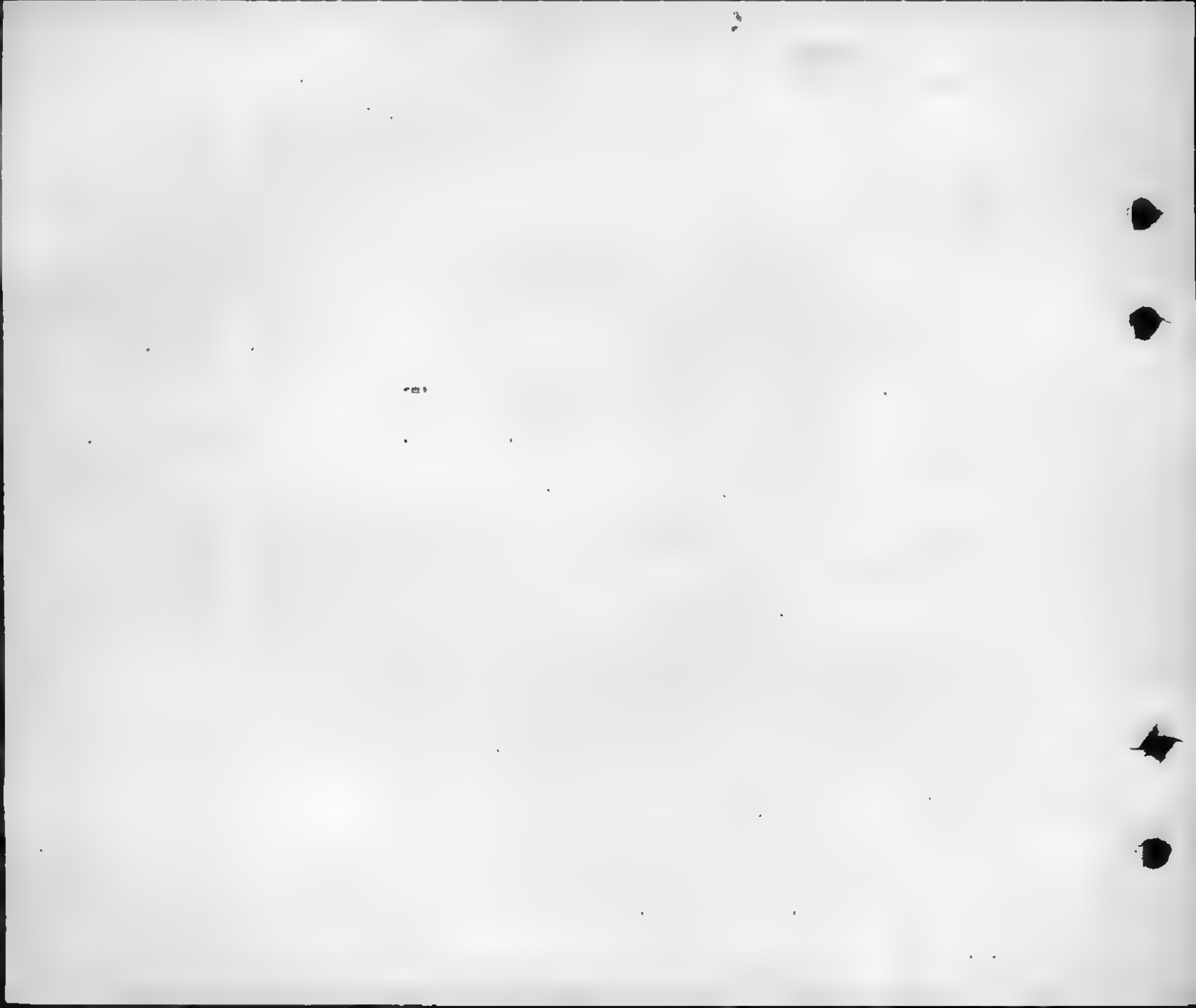
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

9087

99977

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) o. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsburg				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Robert Last Medford				4. DATE OF DEATH Month August Day 29 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1879		9. AGE (In years last birthday) 82 yrs	10. UNDER 1 YEAR Months 82 Days 0 Hours 0 Min 0	11. UNDER 24 HRS Hours 0 Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert W. Medford				14. MOTHER'S MAIDEN NAME Sarah Harper			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Julia M. Medford, Williamsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY ARTERY THROMBOSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROSIS (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH 1/2 HR.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BENIGN PROSTATIC HYPERTROPHY							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 10 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from 10/10 to 8/29 19 61 that (I) (we) last saw the deceased alive on 8/29 19 61 and that death occurred at 11 AM , from the causes and on the date stated above							
22a. SIGNATURE W. H. Hanks				22b. ADDRESS CAMBRIDGE Md. 130/61			
22c. PHYSICIAN'S NAME (Type) W. H. HANKS				22d. ADDRESS CAMBRIDGE Md. 130/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 1, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		23d. LOCATION (City, town, or county) (State) Near Williamsburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE SEP 5 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hanks	

bfp



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9088 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 9079

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge c. LENGTH OF STAY IN (b) 6 yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Eastern Shore State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Golt d. STREET ADDRESS 14X e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Joseph W. Peacock First Middle Last		4. DATE OF DEATH Month August Day 5 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20/72
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-lumberman		12. KIND OF BUSINESS OR INDUSTRY Farm	
13. BIRTHPLACE (State or foreign country) Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Unknown		16. MOTHER'S MAIDEN NAME Unknown	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		18. SOCIAL SECURITY NO ---	
19. INFORMANT Records E.S.S. Hospital- Cambridge, Md. Address		20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 903.7 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture neck left femur DUE TO (c)	
21. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis		22. INTERVAL BETWEEN ONSET AND DEATH 5 Min. 22 days.	
23. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		24. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped and fell to floor.	
25. TIME OF INJURY Month, Day, Year 6:30 AM 7-14- 61	26. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	28. (City or town) (County) (State) Cambridge Dor. Md.
29. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
30. ACTUAL SIGNATURE John Mace Jr. EXAMINER'S NAME (Type)		31. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 8/5/61	
32. BURIAL CREMATION REMOVAL (Specify) Burial	33. DATE THEREOF 8/7/61	34. NAME OF CEMETERY OR CREMATORY Memorial Cemetery	35. LOCATION (City, town, or county) (State) Springfield Md.
36. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus		37. ADDRESS Middletown	38. REC'D BY REGISTRAR Arthur L. Kraus DATE AUG 8 61

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, marking the word "pending" in pencil in item 18. Give Pages 1, 2, 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Arrival 8/5/61 Hemlock County
Oregon RR.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9089

CERTIFICATE OF DEATH

Reg. Dist. No.

119080

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. COUNTY <u>MARYLAND</u> b. COUNTY <u>CHARLOTTE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1 RIDGELY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>208-2</u>	
3. NAME OF DECEASED (Type or print) <u>LILLIE</u> First Middle Last		4. DATE OF DEATH <u>AUGUST 18</u> 19 <u>61</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 24, 1871</u> 89
9. AGE (In years (on birthday)) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>MICHAEL H. SWING</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Myrtle Robertson</u> Address <u>Clayton, Del.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 1 month 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> 5 yrs DUE TO (c) <u>Intertrochanteric Fracture left hip</u> 1 month			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/17/61</u> 19 <u>61</u> to <u>8/17/61</u> 19 <u>61</u> , that I last saw the deceased alive on <u>8/17/61</u> 19 <u>61</u> , and that death occurred at <u>6:50</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 Race St.</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Lawrence Maryanov</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Lawrence Maryanov</u>		<u>Cambridge, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Aug 21, 1961</u>	<u>Denton</u>	<u>Denton, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Anwarson</u> ADDRESS <u>Denton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 24 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Charles S. Henth</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and properly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.

3 after death: Page 4

Pages 1 and 2 should be filed with
Then please remove carbon papers. Pages 1 and 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9090

CERTIFICATE OF DEATH

Reg. Dist. No.

99081

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester, Co.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate, Maryland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wingate			
c. LENGTH OF STAY IN 1b Life				d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lorena Middle Jones Last Reynolds				4. DATE OF DEATH Month 8 Day 7 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 27, 1884	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 7 Days 7		IF UNDER 24 HRS Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James E. Jones				14. MOTHER'S MAIDEN NAME Amanda Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO Unknown		17. INFORMANT Mr. Alfred Reynodls, Wingate, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hemorrhage Bladder				INTERVAL BETWEEN ONSET AND DEATH 3 days			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month 19 Day 19 Year 1961 Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-12 , 19 61 to 8-1 , 19 61 , that I last saw the deceased alive on 8-1 , 19 61 , and that death occurred at 4 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 3 Church St. Cambridge, Md. DATE SIGNED Arthur E. Kline							
ACTUAL SIGNATURE W. N. Baumann, M.D. M.D. 3 Church St. Cambridge, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/9/1961		22c. NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Le Compte Funeral Service, Cambridge, Md.,				24a. REC'D BY REGISTRAR DATE AUG 16 '61		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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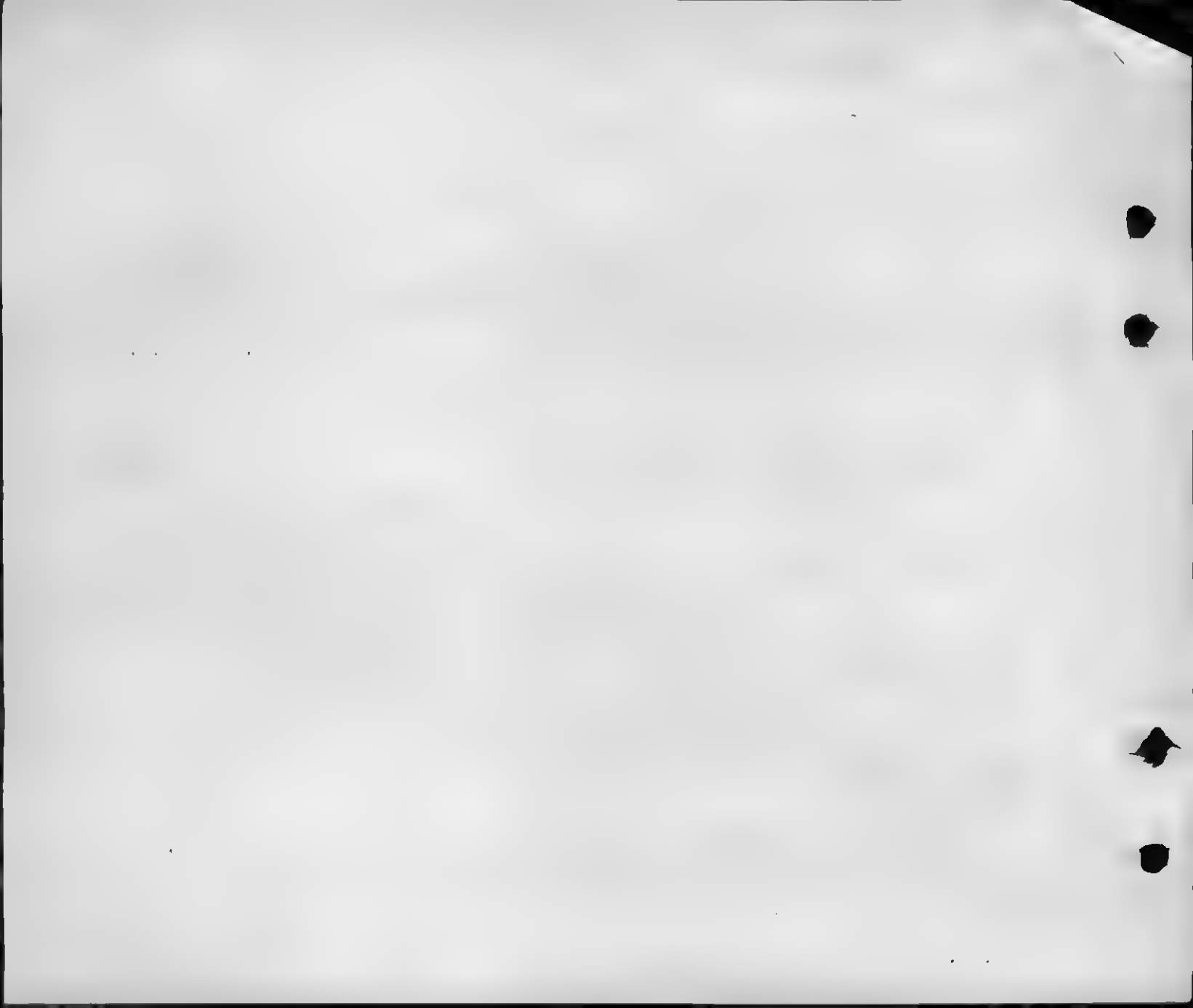
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
9091 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12082											
1. PLACE OF DEATH a. COUNTY Dorchester						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salem						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hgwy. U.S. 50						d. STREET ADDRESS Boonsboro Rt. #2					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) Rosie		First Mae		Middle Shank		Last		4. DATE OF DEATH August 7 19 61		Month 21X-2 Day 7 Year 19 61	
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 12/26/1898		9. AGE (In years last birthday) 62 yrs		10. IF UNDER 1 YEAR 2 Months 11 Days 11 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY CWN. HOME				11. BIRTHPLACE (State or foreign country) Boonsboro Md. #2		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME HARRY E. SMITH						14. MOTHER'S MAIDEN NAME ARNOLD Fannie Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 7					
17. INFORMANT Mrs. Hazel Smith						Address Boonsboro Md. Rt. #2					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intracranial injury											
DUE TO Multiple fractures skull											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 16X											
DUE TO Instant											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger in auto, in collision with another auto.					
20c. TIME OF INJURY 8/7/61 Month 8 Day 7 Year 19 61						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Rt. 50 Near						20f. (City or town) Salem, Dor. Md. (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. John Mace Jr. M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) Dr. John Mace Jr. M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 8/10/61					
22c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery						22d. LOCATION (City, town, or country) Boonsboro Md. (State)					
23. FUNERAL DIRECTOR Kenneth R. Thomas Jr.						24a. REC'D BY REGISTRAR Aug 14 1961					
						24b. REGISTRAR'S SIGNATURE Carlisle S. Thomas					

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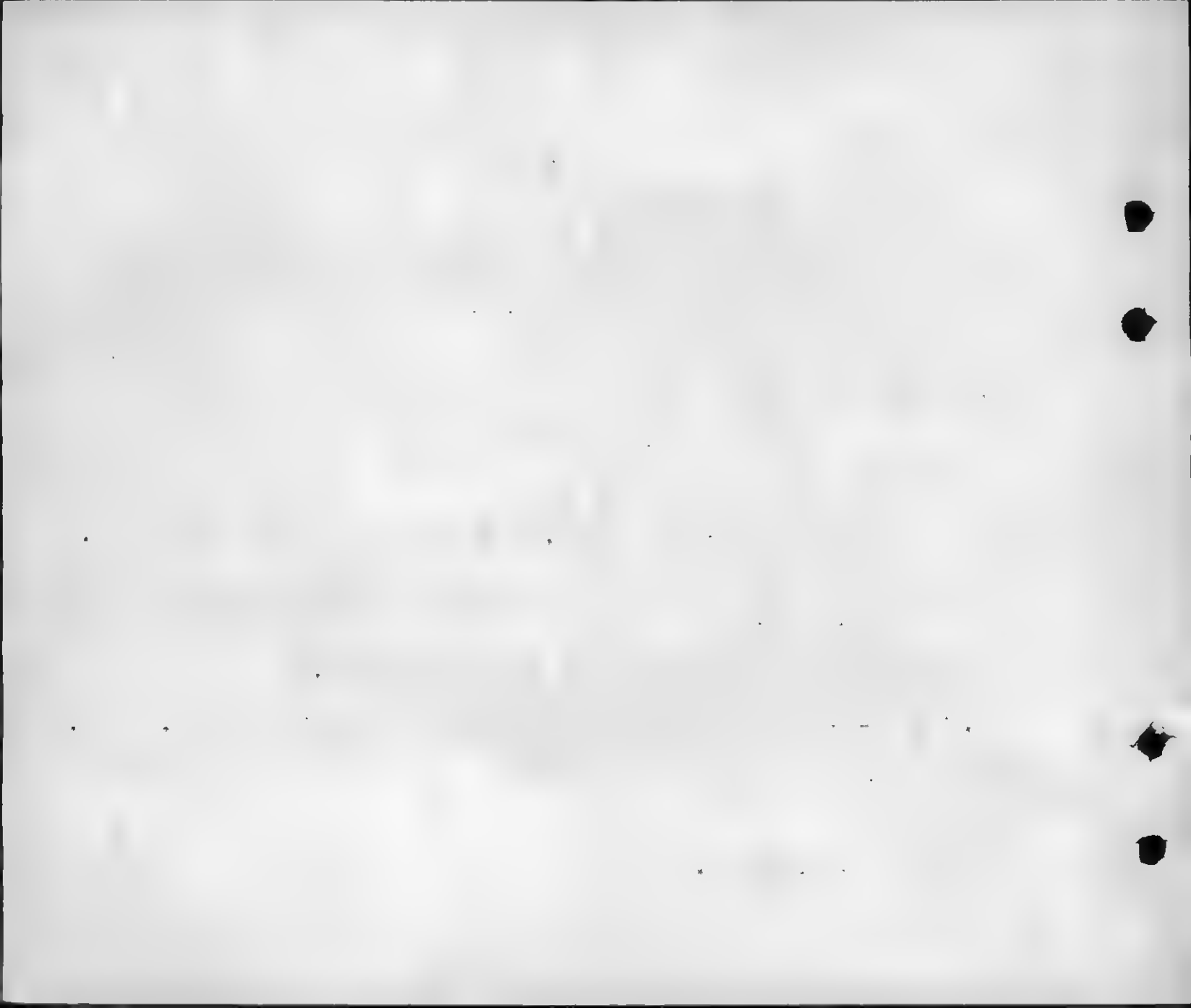
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Form PM3 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 48484

1. PLACE OF DEATH a. COUNTY Dorchester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Galestown	
3. NAME OF DECEASED (Type or print) First Middle Last Houston Wesley Wheatley		4. DATE OF DEATH Month Day Year August 23 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-18-1885
9. AGE (in years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Wheatley	
14. MOTHER'S MAIDEN NAME Mary Thompson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. -		17. INFORMANT RECORDS: Eastern Shore State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal pneumonia DUE TO (b) Fracture neck r. femur DUE TO (c) So nile brain disease CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) So nile brain disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. Slipped and fell on ward of hospital.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Slipped and fell on ward of hospital.		20c. TIME OF INJURY Month, Day, Year 7:25 AM 6-30-61 19	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20f. (City or town) Cambridge		20g. (County) Dor.	
20h. (State) Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) John Mace Jr.		DATE SIGNED 8/24/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-26-61	
22c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET		22d. LOCATION (City, town, or county) EAST NEW MARKET, MD	
23. FUNERAL DIRECTOR'S SIGNATURE SMITH FUNERAL HOME, SHARPTOWN, MD		24a. REC'D BY REGISTRAR AUG 29 '61 DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines			



9094 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09085

1. PLACE OF DEATH a. COUNTY Dorchester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Vienna		c. LENGTH OF STAY IN b. Few Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Vienna		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Jonnie L. Wilson		First Middle Last		4. DATE OF DEATH Aug. 5, 1961		Month Day Year	
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 5, 1915	
9. AGE (In years last birthday) 45 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Wilson		14. MOTHER'S MAIDEN NAME Annie Carpenter		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 425-34-2713	
17. INFORMANT Annie C. Wilson, Winona, Miss.		Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhage 981X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) Gunshot wounds abdomen DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Few minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was shot 5 times by another man.					
20c. TIME OF INJURY Month, Day, Year 12:10 a.m. 8/5/61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dorco Labor Camp Nr. Vienna, Dor. Md.		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input checked="" type="checkbox"/> . Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/10/61	
ACTUAL SIGNATURE John Mace Jr.		M.D.		DATE SIGNED			
EXAMINER'S NAME (Type) Dr. John Mace Jr. M.D.		Address (Street, city, town, or county) Cambridge, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/10/1961		22c. NAME OF CEMETERY OR CREMATORY Winona Cemetery		22d. LOCATION (City, town, or country) (State) Winona, Mississippi	
23. FUNERAL DIRECTOR Richard H. S. S. S.		ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR AUG 14 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

VS. A15ME
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1904



James H. [illegible]
[illegible]
[illegible]

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09086

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linkwood</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>VAN</u> First <u>Byren</u> Middle <u>Wright</u> Last		4. DATE OF DEATH <u>Aug</u> Month <u>3</u> Day <u>1961</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1885</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Wright</u>		14. MOTHER'S MAIDEN NAME <u>Frances Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	
17. INFORMANT <u>Mrs. Alberta Wright - Linkwood, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Hemorrhage</u> 4-22-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 20, 1961</u> , to <u>Aug 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Aug 2, 1961</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. Edwin Fassett</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. Edwin Fassett</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-7-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Eizey's Cem</u>	23d. LOCATION (City, town, or county) (State) <u>Jesterville Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James R. Smith</u>		25a. REC'D BY REGISTRAR DATE <u>Aug 9 '61</u>	
ADDRESS <u>Easton, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

(M)

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THE STATE OF CALIFORNIA

COUNTY OF

IN SENATE,
January 1, 1901.

REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

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JANUARY 1, 1901
CALIFORNIA
LAND OFFICE
SACRAMENTO
CALIFORNIA